EUTF Enrollment/Change Form for Active Employees

1. Social Security No.	2. Employee's Name (Last, First, M.I.)	3. Date of Birth Month / Day / Year _____/_____/_____

4. Sex ☐ Male ☐ Female	5. Marital Status ☐ Married ☐ Single

6. Phone Number - Home	7. Street Address		
6a. Phone Number – Work	7a. City	7b. State	7c. Zip code

8. Plan Selections, Changes or Cancellations

First, decide the coverage you want, "Self" or "Family." Please make your selection by checking the blocks for appropriate benefit plans below. The medical, drug and chiropractic plans are available as a bundle. You cannot enroll in any one of them individually. You are only eligible for the dual coverage plan if you have medical, dental or vision coverage from a source other than the EUTF. Codes for the Action column are: A – Add; C – Change Information, D – Delete Coverage, W – Waive Coverage.

Medical, Drug, Chiropractic (choose one)	Self	Family	Action
HMSA PPO Medical and Drug, MBAH ChiroPlan	☐	☐	_____
Kaiser Medical and Drug, MBAH ChiroPlan	☐	☐	_____
Dental (choose one)			
HDS Dental	☐	☐	_____
HDS Dual Coverage Dental	☐	☐	_____
Vision (choose one)			
VSP Vision	☐	☐	_____
VSP Dual Coverage Vision	☐	☐	_____

9. State of Hawaii Employees Only – I HEREBY ELECT TO (choose one):

☐ ENROLL in the Premium Conversion Plan (PCP) so that my monthly employee contribution (premium) for my health insurance benefit plans will be paid using pre-tax payroll deducted monies, to the extent permitted. I have read and understand the PCP General Information section in the benefit booklet.

☐ NOT ENROLL in the Premium Conversion Plan, and instead, use after-tax payroll monies for my monthly premiums.

☐ CHANGE the amount of my PCP reduction for the plan(s) checked in number 8 above.

☐ CANCEL my PCP reduction for the plan(s) checked in number 8 above.

10. Certification: I certify that the information provided in this application is true and complete. I agree to abide by the terms and conditions of the benefit plans I selected. I authorize my employer or finance officer to set my effective dates of coverage and to make the pre-tax or after-tax deductions, adjustments or cancellations from my salary, wages, pension or other compensation for my monthly employee contribution in accordance with applicable laws, rules and regulations.

I affirm that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student.

I affirm that I have non-EUTF plan benefits for each Dual Coverage Plan I selected.

Signature _____ Date:_____

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11. If you made a "Family" coverage selection in Section 8, list all dependents to be covered, including your Spouse, Domestic Partner, Children or Students. If you are adding a Domestic Partner (DP), please refer to the instructions. If you are enrolling a domestic partner's child, please circle both the Child and DP relationship. Codes for the Action column are: A – Add; C – Change Information, D – Delete Coverage

First Name, M.I., Last Name (if different from employee)	Date of Birth (MM/DD/YY)	Social Security Number	Relationship (Circle One)	Gender (Circle One)	Action
			Spouse	M F	
			DP	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	
			Child DP Disabled	M F	

Other Information or Comments: .....

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For DPO USE:

12. Employer (Check One)	13. Department Division or School	14. Date of Coverage	15. Bargaining Unit
☐ State of Hawaii ☐ County of Kauai ☐ C&C of Honolulu ☐ County of Maui ☐ County of Hawaii ☐ Bd. Of Water Supply			

I certify that the applicant is an eligible employee-beneficiary as defined in Chapter 87A, HRS.

DPO Signature _____ Date:_____ Phone: _____

For DPOs: Fax the completed form to EUTF at 808-586-2161, make a copy for your records, and then, process this form in accordance with your departmental policies and procedures.